Kentucky Utilization Management
Intake Form

Member Information			
Member Last Name:	Member First Name:		Date of Birth:
Medicaid ID#:	Member Address:	City:	Zip Code:

Provider Information		
Facility Name:	NPI:	Tax ID:
Facility address:	City:	Zip Code:
Facility Contact Person:	Facility Contact Number:	

Request Details:			
Date of Service:	Physician Name:	Provider ID:	
Diagnosis:	ICD 10 Code:	Diagnosis:	ICD 10 Code:
Diagnosis:	ICD 10 Code:	Diagnosis:	ICD 10 Code:
	Qty Requested:	Start Date:	End Date:
Urgent	Standard		
CPT Code:	CPT Code:	CPT Code:	CPT Code:

Form Instructions:

Please complete the sections above for the Medicaid member you are requesting services for. **You must submit clinical documentation to support the medical necessity of this request** to include at a minimum: a Facesheet, History and Physical, Emergency Room Summary, lab work, x-ray results, discharge plans, and any other clinical documentation including any assessments that will assist with the reviewer's assessment of InterQual criteria for approval/denial.

If information is missing or deemed not sufficient you will receive a Lack of Information notice which will request additional documentation. Please note this request does not guarantee services will be authorized.

Notes/Additional Comments: